DEPARTMENT POLICY

Family Independence Program (FIP), Refugee Cash Assistance (RCA), State Disability Assistance (SDA), Child Development and Care (CDC), Medicaid (MA), Food Assistance Program (FAP)

Process the following case actions:

- Initial applications and reapplications; Bridges Administrative Manual (BAM) 115, Application Processing.
- Redeterminations; BAM 210.
- Reinstatements; BAM 205.

Bridges will evaluate each change reported and entered in the system to determine if it affects eligibility.

Exception: For Medicaid only**,** the Michigan Department of Health and Human Services (MDHHS) health services side, shares responsibility for medical services authorization (MSA) and certain related determinations when a recipient in managed care becomes a Long Term Care/Hospital patient; see BAM 120, DCH/DHS Coordination, for details.

Changes in circumstances may be reported by the client, via computer tape matches, through quality assurance (QA) reviews, or by other means.

A **positive action** is a Michigan Department of Health & Human Services (MDHHS) action to approve an application or increase a benefit.

A **negative action** is a MDHHS action to deny an application or to reduce, suspend or terminate a benefit. This includes an increase in a post-eligibility patient-pay amount for MA or an increase in the client pay for a special living arrangement.

CDC Only

Changes reported by clients may affect eligibility for other programs but **may not** affect the current CDC eligibility or benefit. Only changes that would positively affect the client's family contribution (FC), or authorized hours, unless a negative action is required or allowed in the following situations:

- Those listed in the CDC EDG Closure Reasons; see BAM 220.
- An FC increase tied to a provider change.
- A case correction required due to an incorrect eligibility determination (regardless of client or agency error).

Note: For the dates of November 7, 2021, through September 23, 2023, the FC amount will be waived for all children approved for the CDC subsidy. This temporary change is possible due to additional federal funding. When this temporary change ends, standard policy will be applied, and each child's FC will be based on the most recent CDC eligibility determination and current provider assignment. If an FC amount is assigned this will not be considered a negative action.

CDC clients are required to report, within 10 calendar days, changes in:

- Group composition/death.
- Out of state residency.
- Providers or child care setting.
- Assets that exceed $1 million.
- When income exceeds the income eligibility scale for the family size; see RFT 270.

Note: See BEM 703, Request for Additional Assistance, for policy pertaining to a request for an additional provider, need reason or need hours for an active client during the 12-month continuous eligibility period.

NOTICE OF CASE ACTIONS

All Programs

Upon certification of eligibility results, Bridges automatically notifies the client in writing of positive and negative actions by generating the appropriate notice of case action. The notice of case action is printed and mailed centrally from the consolidated print center.

For **FAP Only**, see Actions Not Requiring Notice in this item.

Exception: Written notice is **not** required to implement a hearing decision or policy hearing authority decision.

Refer to policy in BAM 600, Hearings, if a client disputes a case action.

There are two types of written notice: **adequate** and **timely**.

A notice of case action must specify the following:

- The action(s) being taken by the department.
- The reason(s) for the action.
- The specific manual item which cites the legal base for an action or the regulation or law itself.
- An explanation of the right to request a hearing.
- The conditions under which benefits are continued if a hearing is requested.

Adequate Notice

An adequate notice is a written notice sent to the client at the same time an action takes effect (not pended). Adequate notice is given in the following circumstances:

All Programs

- Approval/denial of an application.
- Increase in benefits.

FIP, RCA, SDA, MA, CDC

- A recipient or his legal guardian or authorized representative requests in writing that the case be closed.
- Factual information confirms a recipient's death.
- It is verified that a recipient has been approved for assistance in another state.
- It is verified that an eligible child, **or in MA,** an eligible group member of any age, has been removed from the home as a result of court action.

FIP, SDA, and FAP Only

An intentional program violation (IPV) disqualifies the only eligible member or reduces/terminates other members' benefits. See the

DISQUALIFICATION section in BAM 720, Intentional Program Violation, for notice procedures and forms.

FIP and MA Only

Denial of request for medical transportation.

SDA Only

Case closure due to a member's receipt of Supplemental Security Income.

CDC Only

- The client or provider reports, orally or in writing, that a child is no longer in the care of that provider.
- It is verified that a child member of the program group was voluntarily placed in foster care.
- Information verifies the provider is no longer eligible to receive payments.

MA Only

- Case opening with a deductible or patient-pay amount.
- Decrease in post-eligibility patient-pay amount.
- Recipient removed due to his eligible status in another case.
- Addition of MA coverage on a deductible case.
- Increase in medical benefits.
- At case open with a divestment penalty

FAP Only

- Negative action results from information on the DL-060, Child Support Information Report.
- The change was reported in writing and signed by an eligible group member **and** the new benefit level or ineligibility can be determined based **solely** on the written information.

  Note: When deleting a member, an application the client files on their own, **or** the updated application of a group they join, is considered a change reported in writing by an eligible member of the former group.

- Reliable information indicates the group will leave the state before the next issuance.
- Changes reported on a DHS-1046, Semi-Annual Contact Report.

Timely Notice

All Programs

Timely notice is given for a **negative action** unless policy specifies adequate notice or no notice. See Adequate Notice and, for FAP only, Actions Not Requiring Notice, in this item. A timely notice is mailed at least 11 days before the intended negative action takes effect. The action is pended to provide the client a chance to react to the proposed action.

Actions Not Requiring Notice

FAP Only

A notice of case action is **not** sent in the situations below. The action must take effect no later than the month after the change.

- Reliable information indicates the group left the state.
- Reliable information indicates all members died. Reliable sources generally include a newspaper, friends or relatives of the group, or other agencies.
- Supplementation over multiple months to restore lost benefits is completed; see BAM 406, Supplemental Food Assistance Benefits.
- From a joint FIP/SDA and FAP application, the FAP benefit began first **and** the FAP approval letter indicated the benefit might decrease if FIP/SDA were later approved.
- The FAP benefit varies from month to month within the benefit period due to changes anticipated when the case was certified, **and** the group was so notified at that time.
- Benefits are reduced for failure to repay a FAP overissuance that resulted from IPV (BAM 720, Intentional Program Violation) or client error (BAM 715, Client/CDC Provider Violation); see BAM 725, Collection Actions.

- The FAP certification period has expired and redetermination application was not filed.
- The group voluntarily requests closure in writing.

Child Care Provider Authorization

CDC Only

Bridges generates a DHS-198, Child Development and Care (CDC) Provider Notice, to notify CDC providers when:

- An authorization is added.
- The authorized hours change.
- Closing the CDC eligibility determination groups (EDG).
- The family contribution changes.

A manual DHS-198 must be sent by the specialist when a manual authorization is entered in Bridges.

MASS UPDATES

All Programs

Certain changes result from changes by the federal or state government and involve mass updates of the entire or major portions of the caseload. Central office usually processes most of the affected cases through Bridges mass update and mails notices to client. Local offices are often required to assist in a mass update, as specified in a program policy bulletin.

Mass updates affecting various programs include:

- Annual FAP standards update.
- Retirement, survivors, and disability insurance (RSDI) updates.
- Periodic changes in program benefit amounts.
- Other changes in eligibility factors based on laws or regulations.

STANDARDS OF PROMPTNESS

All Programs

The standard of promptness (SOP) is the maximum time allowed to complete a required case action. Cases should be processed as quickly as possible. The SOP sometimes varies by program.

Change Reported Via Tape Matches

All Programs

Case actions resulting from changes reported via tape match (BENDEX, SDX, IRS, enumeration, etc.) must be completed within 45 days of receiving the information.

It is a best practice to resolve information obtained from a State New Hires report and/or a National Directory of New Hires report within 21 calendar days from the date the match is reported to the specialist.

All Other Reported Changes

FIP, RCA, SDA, CDC and MA

Act on a change reported by means other than a tape match within 15 workdays after becoming aware of the change.

FAP Only

Act on a change reported by means other than a tape match within 10 days of becoming aware of the change.

Benefit Increases: Changes which result in an increase in the household's benefits must be effective no later than the first allotment issued 10 days after the date the change was reported, provided any necessary verification was returned by the due date. A supplemental issuance may be necessary in some cases. If necessary verification is **not** returned by the due date, take appropriate action based on what type of verification was requested. If verification is returned late, the increase must affect the month after verification is returned.

Example: Rich reports on March 23rd that he now has a dependent care expense. Act on the change by April 2nd. May's

benefits will be the first month affected because the 10th day after the change is reported falls in the next benefit period. Affect the April issuance if the action can be completed by March 31st.

If verification is required or deemed necessary, allow the household 10 days from the date the change is reported to provide the verification. The change must still affect the correct issuance month. For example, the first benefit month occurring 10 days after the date the change was reported.

Example: Rich reports a dependent care change on March 21st. However, verification of his new dependent care obligation is requested late on March 23rd. Rich provides the verification on April 2nd. Make the change to affect April's benefits by using a supplemental issuance.

If verification is required or deemed necessary but the client fails to return the verification within 10 days after the change was reported, but does provide the verification at a later date, act on the change within 10 days after the verification is provided.

Example: Using the previous example, Rich does not supply the dependent card verification until April 6th. Act on the change by April16th to affect May's benefits. No supplement is issued for April, due to Rich's failure to return the verification within 10 days.

Benefit Decreases: If the reported change will decrease the benefits or make the household ineligible, action must be taken and a notice issued to the client within 10 days of the reported change.

Example: Debra calls on March 22nd and reports that her husband left the home. Act on the change and issue the negative action notice by April 1st. The change will be effective for May's benefits.

Example: Mary calls on March 19th and reports that her rental expense went from $300 per month to $250 per month and is questionable. Even though Mary must be allowed 10 days to return verification of her decreased shelter costs, act on this change and issue the negative action notice by March 29th. If the verification is not returned within 10 days, begin a second negative action to remove the expense completely.

EFFECTIVE DATE OF CHANGE

All Programs

Bridges evaluates the following dates entered in data collection to determine positive action dates, negative action dates and effective dates:

- Circumstance start/change date.
- Reported on.
- Verification received on.
- Date client became aware.

FIP, RCA, SDA and FAP Only

See BEM 505, Prospective Budgeting/Income Change Processing, for policy regarding effective dates for income changes.

FIP, RCA and SDA Only

See Bridges Eligibility Manual (BEM) 515 FIP/RCA/SDA Budget, for policy regarding effective dates for member adds.

CDC Only

Act on reported changes as soon as possible, but act within the standard of promptness; see STANDARDS OF PROMPTNESS in this item. The day a reported change is acted on is not always the day the change must take effect.

Example: A client had prior pay periods certified for CDC. The client failed to timely report an increase in income that exceeded the income eligibility scale for the family size. If the income is not temporary excess income, rerun eligibility. Bridges will generate zero approved hours or an over-payment. The client will then be denied the pay period after the change occurred for excess income.

Note: Determine if the increase is temporary excess income, or is expected to continue; see BEM 505.

Positive Actions can be entered on Bridges to affect current, future, and past CDC pay periods. First determine the positive action date. If the change was reported timely (within 10 calendar days), for example a change in providers, the positive action date is the day the change occurred or is expected to occur. If the change was reported late, the positive action date is the day the change

was reported. Positive actions take effect on the positive action date.

Exception: Family contribution decreases, that are not a result of a provider receiving a higher star rating are positive actions and affect the first CDC pay period that begins on or after the positive action date.

Note: For a new or changed authorization to take effect on the positive action date, begin it the first day of the CDC pay period that contains the positive action date.

Negative Actions: If timely notice is required, the negative action date must be the first workday at least 11 days after the notice was sent, or the date the change is expected to occur if that is later. If adequate or no notice is required, the negative action date is immediate (the day action is taken on the change), but not before the change is expected to occur.

The following negative changes entered on Bridges take effect as follows:

- Family contribution increases tied to a provider change are a negative action and take affect the first CDC pay period that starts on or after the negative action date.

  Note: An income eligible child assigned to a 3 star or higher provider will have their FC amount waived. During the 12-month continuous eligibility period a change to a provider with 2 star or lower rating (or a change in the currently assigned provider's star rating) will result in the FC amount no longer being waived. For additional family contribution details; see BEM 706.

- CDC case closures and member removals (for example removing an eligible child) take effect on the negative action date.

FAP Only

For non-income changes, complete the FAP eligibility determination and required case actions in time to affect the benefit month that occurs 10 days after the change is reported. See BEM 212, Food Assistance Program Group Composition, and BEM 550, FAP Income Budgeting, for policy regarding effective dates for member adds. The benefit month **cannot** be earlier than the month of the change.

Example: A $30 shelter increase reported on May 15th would increase the household's June allotment. If the same increase were reported on May 28, the household's allotment would have to be increased **by** July. (The 10th day following May 28 would be June 7.) However, the first month we **can** affect is June, provided the action on the shelter change is completed by May 31st.

PROCESSING CHANGES

All Programs

Enter all changes in Bridges by changing the affected data elements. Certify the eligibility results in Bridges for all appropriate benefits and benefit periods.

Negative Actions

A **negative action** is identified in Bridges with notice reason(s) in eligibility results. Negative actions include:

- Decrease in program benefits, including case or EDG closure.
- Special living arrangement client pay increase.
- Inactivation of an eligible group member.
- CDC family contribution increases tied to a provider change.
- Change in payment method to restricted payment (no code needed). Termination of a member's medical eligibility (member remains active but **not** medically eligible).
- Medical coverage cancellation or reduction.
- Inactivation resulting in a FAP benefit increase is **not** a FAP negative action.
- Patient-pay amount initiated (**unless** this occurs on the day of case opening).
- Post-eligibility patient-pay amount increase.
- Changing the PET code to a divestment penalty code; see BEM 405, MA Divestment.

FAP Only

Reducing a FAP group's benefits at redetermination is treated as a **positive action** because the change affects the new certification, **not** the current benefit period.

CDC Only

For CDC when a foster child is adopted by the child's current foster parents during the 12-month continuous eligibility period, CDC should remain open until redetermination with no negative action taken on the CDC EDG. Assistance from the Bridges Resource Center (BRC) is required.

During 12-month continuous eligibility, complete a case correction, including those constituting negative actions, when initial eligibility or redetermination was completed in error or when it is discovered that inaccurate information was provided by the applicant.

Notice Reasons

All Programs

The notice reason(s) in Bridges indicates the reason for the action.

NEGATIVE ACTION DATE

Bridges automatically calculates the negative action effective date. The negative action effective date in Bridges is the day after the timely hearing request date on the Bridges notice of case action.

Timely Hearing Request Date

The timely hearing request date is the last date on which a client can request a hearing and have benefits continued or restored pending the hearing. It is always the day before the negative action is effective.

Immediate Negative Actions (Adequate Notice)

An immediate negative action occurs when the negative action requires adequate notice based on the eligibility rules in this item. Adequate notice means that the action taken by the department is effective on the date taken.

Exception: For CDC adequate notice means that the action taken by the department is effective on the date of the Circumstance Start/Change Date (CSCD).

Pended Negative Actions (Timely Notice)

A pended negative action occurs when a negative action requires timely notice based on the eligibility rules in this item. Timely notice means that the action taken by the department is effective at least 12 calendar days following the date of the department's action.

ACTIONS NOT ALLOWED BY LOCAL OFFICES

Bridges automatically sets all negative action effective dates based on the rules for each program and the date the action is processed in the system. Occasionally there is a need to affect a negative action with less than 12 days notice (11 days added to the current date). An exception may be requested for the specific program. Follow the procedure for requesting exceptions found in BEM 100, Introduction. The program office will validate the need for the exception and forward the request to the appropriate staff to enter the override in Bridges.

DELETING A NEGATIVE ACTION

All Programs

Negative actions must be deleted from Bridges in some situations.

Hearing Requests

Record the hearing request date and complete all required information on the Hearings Restore Benefits screen in Bridges. Then follow Additional Steps to Delete a Negative Action in this section; see BAM 600, Hearings.

Requirement Met Before Negative Action Effective Date

Enter the information the client provided to meet the requirement that caused the negative action, using the appropriate Bridges screens. Then follow Additional Steps to Delete a Negative Action in this section.

Additional Steps to Delete a Negative Action

Take these additional steps to delete a negative action in Bridges:

- Reactivate the program(s) on the Program Request screen in Bridges.
- Run eligibility and certify the results.

Bridges will automatically recalculate benefits based on the information and dates entered in the system; see *effective date of change* in this item.

BENEFIT SUSPENSION

FIP, RCA, SDA and FAP Only

Benefit suspension means stopping program benefits for one month due to temporary ineligibility when allowed by policy. Document the reason(s) in the case record.

To suspend benefits for one month, check the *TempInelig* box on the initial eligibility results screen in Bridges before continuing to the certification screen. Do **not** check the box if ineligibility will continue beyond one month.

This option is not available in Bridges if the previous month's benefits were suspended.

If **timely notice** is required, the date of the first benefit credited must be later than 11 days from the date the MDHHS-176, Benefit Notice, is sent.

FIP, RCA and SDA Only

If suspending cash assistance benefits, notify any shelter vendor(s) for the case that vendor warrants will not be produced for that month. The client is responsible to pay any vendors directly.

CDC MEMBER ADDS

When a client reports a new person in the home, determine if any actions must be taken. Complete a telephone interview and inform the head of household that they must report if assets exceed $1 million and if income exceeds the eligibility limit by family size in the *CDC Income Eligibility Scale*; see RFT 270.

When adding an adult group member, document the request in case comments and obtain and enter the following information in Bridges:

- Citizenship/non-citizen status.

When adding a child, document the request in case comments and enter the following additional information in Bridges:

- Citizenship/non-citizen status.
- Absent parent information, if applicable.
- Age exception, if the child is 13 through 18 years of age.
- Does the child meet the immunization requirement.

If CDC is active and requested for an additional child, and the parent/substitute parents (P/SPs) currently in the home were part of the most recent eligibility determination, verification of income, need reason and hours should not be requested. The new child's authorizations should be based on the most recent CDC eligibility determination.

If CDC is active and requested for an additional child, and that child has a P/SP in the home who was not part of the most recent eligibility determination, the new P/SP must verify all required eligibility factors in order to make an eligibility decision for the added child.

Note: Currently authorized children should not be negatively impacted, except for valid closure reasons.

Example: CDC is open for Child A, and Child A's mother (only P/SP) and her Living Together Partner (LTP) are in the home. The mother and her LTP wish to add a new child-in-common (Child B)

to the CDC case. The LTP is a P/SP to Child B, a required program group member, and was not a part of the most recent CDC eligibility decision. Therefore, the LTP must verify all required eligibility factors at member add in order to authorize CDC for Child B.

Before adding a provider assignment to the new child, obtain a new DHS-4025.

Note: At the redetermination following any member add, review the CDC need and income of all mandatory group members.

Adding the new member may result in a positive or no change in benefits; see *effective date of change* in this item.

SHORTENING A 24-MONTH FAP BENEFIT PERIOD

FAP Only

Bridges will shorten the FAP benefit period for groups assigned a 24-month benefit period when a change is reported which changes the group's status so that it no longer meets the criteria for a 24-month benefit period.

Bridges sends a DHS-1605, Notice of Case Action, to inform the FAP household that the benefit period has been shortened to the month after the DHS-1605 is sent; see BAM 210, Redetermination/ExParte Review.

SHORTENING THE FAP BENEFIT PERIOD DUE TO EARNINGS

FAP Only

For ongoing cases that report starting countable earned income and qualify for FAP simplified reporting, Bridges will do all of the following:

- Shorten the benefit period to 12 months after the change is processed, provided the number of months remaining in the FAP benefit period is more than 12 months.

- Send the client a DHS-265, Shortened Benefit Period and a DHS-1045, Simplified Six-Month Review.

Example: On August 8, 2009, the FAP group reports starting income. The change is processed on August 17th. The current FAP benefit period ends June 30, 2011. Bridges changes the FAP benefit end date to August 31, 2010 and sends the FAP group a DHS-265, and DHS-1045.

SSI CASE ACTIONS

SSI Openings and Changes

FIP, RCA, SDA and MA Only

Bridges generates tasks that provide SSI data reported by the Social Security Administration (SSA) on the State Data Exchange (SDX) system.

Bridges acts on specific HR-070 information to prevent benefit duplication or mispayment.

SDA Only

Take appropriate action based on a Bridges Task that SSI benefits have started or changed.

Enter amounts from the SSI AMOUNT and SSI ELIG SDX interface fields from the SDX interface to recalculate SDA eligibility and benefits.

Note: Whenever the SSI benefit changes, a task will be generated for SDA cases containing SSI recipients.

FIP Only

Persons **cannot** receive FIP **and** SSI at the same time. Also, central office **cannot** open a manual SSI case for an SSI recipient who is a certified group member in a FIP EDG.

Run EDBC to remove the SSI recipient from the FIP certified group.

MA Only

See BEM 150, MA For SSI Recipients.

FAP Only

Enter the ongoing SSI benefits as unearned income.

SSI APPLICATION DENIALS

SSI-Related MA Only

The SDX reports SSI denials and appeals. Exhibit III in BEM 260, MA Disability/Blindness, lists the specific codes needed to identify appeals and disability/blindness denials.

Eligibility for MA based on disability or blindness does **not** exist if the SSA disability determination is **final** as defined in BEM 260, MA Disability/Blindness. Enter appropriate appeal information in Bridges.

If the client is no longer eligible for disability-related MA, Bridges will explore other MA categories. If the client is **not** eligible for any, Bridges will close the MA. If the client qualifies for a category but must meet a deductible, Bridges will close MA based on disability and open an active deductible EDG under the new MA category.

Timely notice of benefit reduction or closure is sent by Bridges.

SSI Terminations

MA Only

Central office closes SSI MA when SDX indicates SSI benefits are terminated. Bridges sets a redetermination date and continues MA eligibility when SSI stops.

Continue the beneficiary's MA coverage until the redetermination is completed. The redetermination does not need to be completed if the beneficiary's SSI is reactivated in a subsequent SDX batch. In most cases this is a local office responsibility; see BEM 150, MA for SSI Recipients.

DEATH NOTIFICATION

All Programs

A reliable source must verify a recipient's death before action is taken on a case. Reliable sources generally include death notices in newspapers, friends and relatives of the client, and other

agencies. The verification source is entered in Bridges for the date of death.

CDC Only

Report all deaths of children while in the care of a child care provider; see SRM 172, Child/Ward Death Alert Procedures and Timeframes, for specific reporting instructions.

EX PARTE REVIEW

MA Only

An ex parte review (see glossary) must begin at least 90 days (when possible) prior to the close of any Medicaid Type of Assistance.

- When the ex parte review shows that a recipient does have eligibility for Medicaid under another category, change the coverage.
- When the ex parte review shows that a recipient may have continuing eligibility under another category, but there is not enough information in the case record to determine continued eligibility, send a verification checklist (including disability determination forms as needed) to proceed with the ex parte review. If the client fails to provide requested verification or if a review of the information provided establishes that the recipient is not eligible under any MA category, send timely notice of Medicaid case closure.
- When the ex parte review suggests there is no potential eligibility under another MA category, send timely notice of Medicaid case closure.

When it is determined that a recipient will no longer meet the eligibility criteria for FIP-related Medicaid, because of an actual or anticipated change, determine whether the recipient has indicated or demonstrated a disability (see glossary) as part of the ex parte review (see glossary).

- If the ex parte review reveals the recipient has already been determined disabled for purposes of qualifying for a disability-based Medicaid eligibility category, by the SSA or the department, and the determination is still valid, continue the recipient's Medicaid eligibility under the disability-based Medicaid category for which the recipient is otherwise eligible.

- If, during the ex parte review it is determined a recipient has indicated or demonstrated a disability, request from the recipient additional information needed to proceed with a disability determination. Pending the determination, continue the recipient's Medicaid.

  - If the recipient fails to provide the information requested after being given a reasonable opportunity to do so, and eligibility under all other categories has been ruled out, send timely notice of Medicaid case closure indicating the person is not eligible for disability based Medicaid as well as FIP related categories.

  - If, following the disability determination process, the recipient is determined to not be disabled for purposes of qualifying for disability-based Medicaid categories and eligibility under all other categories has been ruled out, send timely notice of Medicaid case closure indicating the person is not eligible for disability-based Medicaid as well as FIP-related categories.

  - If, following the disability determination process, the recipient is determined disabled for purposes of qualifying for disability-based Medicaid categories, continue the recipient's Medicaid under the disability-based Medicaid category for which the recipient is otherwise eligible.

Medicaid coverage will continue until the client no longer meets the eligibility requirements for any other Medicaid TOA.

CASE CLOSURE

All Programs (Except SER)

When a recipient is no longer eligible or requests case closure, do **all** of the following:

- Enter all appropriate information, including verification sources, in Bridges to document ineligibility, or the client's request that the program(s) be closed.

- Run EDBC in Bridges and certify the eligibility results.

- Make appropriate referrals for other programs or services.

CDC EDG CLOSURE REASONS

The following are valid reasons to end CDC benefits during the 12-month continuous eligibility period:

- Client requests closure.
- Unable to locate.
- Child support non-cooperation (income eligible only).
- Substantiated welfare fraud or IPV sanction.
- Loss of Michigan residency.
- Income exceeds the eligibility scale in RFT 270, and the income increase is not Temporary Excess Income; see BEM 505.
- Only authorized child ages out or leaves the household; see BEM 240 for age requirements.
- Only P/SP on the case leaves the household (no longer resides with the authorized child).
- Minor parent, active on legal guardian's case, turns 18.
- Assets exceed $1 million.
- A case correction that results in closure.

CASE ACTION NOTICE FORMS

FIP, SDA, RCA, CDC and FAP

Bridges sends the appropriate notice based on the case action taken.

Notices are sent to Spanish or Arabic-speaking clients using a Spanish-Arabic form, if available, and if the client has indicated Spanish or Arabic as the household’s written language.

A notice must be generated manually in those situations in which Bridges is not able to generate a notice, as identified in this item.

APPLICATION APPROVALS/ DENIALS

All Programs

The following notices are used to notify the client of an application approval or denial.

The DHS-1150, Application Eligibility Notice, is generated for withdrawals entered on the Program Request screen prior to data collection/intake.

The DHS-1605, Notice of Case Action, is generated by Bridges for automated eligibility determinations.

MA Only

A DHS-114, Deductible Notice, is generated when MA is approved with a deductible.

A DHS-1606, Health Coverage Notice, is generated when Medicaid is approved or denied.

See BEM 402, Special MA Asset Rules, for policy on notices to send regarding asset transfer information and the results of an initial asset assessment.

POSITIVE CHANGES

All Programs

Bridges automatically generates a DHS-1605, Notice of Case Action, to notify the client of the results of the Bridges automated eligibility determination. The results for all programs are included on a combined notice.

NEGATIVE CHANGES AND CASE CLOSURES

All Programs

Bridges generates a combined DHS-1605, Notice of Case Action, for all programs. A DHS-1606, Health Coverage Notice, is generated for Medicaid. Other notices are either generated by Bridges or must be manually completed and sent in the specific circumstances listed below.

FIP, RCA, SDA and FAP Only

Bridges generates the following notices when a claim is created:

- DHS-4357, Client Notice of Disqualification and/or Recoupment.

Note: The DHS-4357 is only generated by the recoupment specialist.

- DHS-4358, Notice of Agency or Client Error Overissuance and Recoupment Action.

FIP and MA Only

Send a DHS-301, Medical Transportation Notice, if a request for medical transportation is denied.

MA EXCEPTIONS UNIT

Certain Bridges transactions must be processed through the Exceptions Unit in MSA. The MA exceptions unit mailbox is MDHHS-EXCEPTIONS@michigan.gov.

The Exceptions Unit Mailbox will accept and assist the Specialist with the following requests:

- Correcting Begin/End dates for PETs beginning with MIC, ING, and EXM.
- Correcting PETs beginning with ICO (if the provider ID is a LTC facility instead of ICO plan provider ID).
- Patient Pay Amount (PPA) changes.
- **Specialist must include the following information in the email request:**

- Beneficiary name.
- Beneficiary ID.
- Beneficiary case number.
- Description of what needs to be updated in Bridges and why.
- Local office staff may need to generate correspondence to support the exception request such as for an increase in a PPA.

Security codes are no longer needed. Please allow up to 2 business days for the request to be completed.

LEGAL BASE

FIP

Social Welfare Act, PA 280 of 1939, as amended
Mich Admin Code, R 400.902

RCA

45 CFR 400

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151-400.3180

MA

42 CFR 431.200-.250
42 CFR 435.912-.913, .919

FAP

7 CFR 273.12-.13, .21